

## **Hartford STD Payroll Processing for Department Payroll Specialist (PRC)**

1. **Employee or Supervisor calls Hartford to file a claim**
  - ☐ Claims with disability date on or after 8/29/09 will go through Hartford
  - ☐ Claims with disability date prior to 8/29/09 will continue the current process through EBSD and get paid through County payroll
2. **PRC receive First Notice Claim Report from Hartford through push reports**
3. **PRC give employee Leave Request for STD-FMLA Packet located at EMACS website < Form**
4. **PRC receive Leave Integration Request from employee**
  - ☐ Check leave balance to make sure requested leave types are available
    - ☒ Home > Compensate Employees > Administer Base Benefits > Use > Leave Accrual Details
  - ☐ Make sure the form is completed correctly
  - ☐ Forward the original form to EBSD Leaves Team-Hospitality, keep a copy for coding employee's timesheet
  - ☐ If you do not receive the integration form back from employee within reasonable time frame, or before Hartford payments start, confirm with the employee that no integration is needed
5. **Hartford approves claim and issue payments**
  - ☐ 1st payment will be issued after the 7-day waiting period for all new claims per Hartford guideline
  - ☐ Payments are issued weekly to employee via paper check or direct deposit
  - ☐ Medicare taxes will be withheld from all employees who are subject to Medicare
  - ☐ Employee may choose to have Federal and/or State taxes withheld from their STD payments
  - ☐ There will be no other employee deductions taken from Hartford payment. Employee may be responsible for payment of benefits
  - ☐ Hartford will issue W-2 for all STD payments

6. PRC receive Explanation of Benefits Summary (EOB) through push reports
  - ☐ Check number: N/A indicate direct deposit
  - ☐ Gross Benefit: this is the amount you need to use on STD calculator
  - ☐ Payment Amount: check amount
  - ☐ Authorized End Date: last day on leave, should match document submitted to EMACS
  - ☐ Last day worked: should match documents submitted to EMACS
  - ☐ EOB will cover Saturday through Friday, you may need multiple EOB reports to complete timesheet for one pay period
7. PRC calculate STD hour using STD Calculator: located Human Resources/Benefits & Services/General/STD Calculator
8. PRC complete Absence request for employee
  - ☐ New TRCs and Earning codes
    - HSF: Hartford Short-Term Disability Full Integration, works like STF expect no payment
    - HSP: Hartford Short-Term Disability Partial/No integration, works like STP except no payment
  - ☐ Complete absence request for all pay periods
9. PRC complete and approve employee timesheet
  - ☐ Time will come in from absence request you completed
  - ☐ Verify the timesheet matches EOB report for current pay period
  - ☐ For the 7 day waiting period you may code leave time or without pay time per employees request
10. On-cycle audit
  - ☐ STD report on Control-D
    - Currently shows employees coding STF & STP; will include all employees coding HSF & HSP
    - Reconcile this report to EOB to make sure:  
Correct hours are coded

**Correct codes are used (HSF & HSP)**

**Everyone coded HSF & HSP is on EOB report**

☐ **Error message TLPE**

☒ **This error message indicates that total leave hours coded are more than standard hours**

**11. PRC is responsible for coding employee's timesheet. If you need help, please contact the paytech that support your department.**

**12. Samples**

☐ **Jane Doe: Full integration**

☐ **Mary Jane Davis: Partial integration**

☐ **John Smith: Modified duty**

☐ **Robert Miles: Return to work**

**LEGEND:**

✓ Deductions over 24 pay periods not taken

H = JARS, employee data changes due to EMACS HR no later than 3:00

P = Payroll adjustments, Step advances, leave extension, paid leave of absence, New Hire JAR Packets due to EMACS no later than noon

☐ County general employees only

▼ Safety Management

EE = Employee eTime Deadline

MGR = Manager/Approver eTime Deadline

DTA = Dept Time Admin eTime Deadline

# 2009 Master Calendar for EMACS Processing

10/08

JANUARY							FEBRUARY							MARCH							APRIL						
S	M	T	W	Th	F	S	S	M	T	W	Th	F	S	S	M	T	W	Th	F	S	S	M	T	W	Th	F	S
					End PP1 ☐ Accrued Holiday													DTA	H						DTA	H	
					1															End PP6							
					2																						
					3																						
					4																						
					5																						
					6																						
					7																						
					8																						
					9																						
					10																						
					11																						
					12																						
					13																						
					14																						
					15																						
					16																						
					17																						
					18																						
					19																						
					20																						
					21																						
					22																						
					23																						
					24																						
					25																						
					26																						
					27																						
					28																						
					29																						
					30																						
					31																						

1st Quarter Ends PP6 (1-6)

Safety comp time cash out (PP9 only)  
all requests must be submitted to EMACS  
Payroll by 4-22.

MAY							JUNE							JULY							AUGUST						
S	M	T	W	Th	F	S	S	M	T	W	Th	F	S	S	M	T	W	Th	F	S	S	M	T	W	Th	F	S
					H															End PP14 + Holiday							
					1																						
					2																						
					3																						
					4																						
					5																						
					6																						
					7																						
					8																						
					9																						
					10																						
					11																						
					12																						
					13																						
					14																						
					15																						
					16																						
					17																						
					18																						
					19																						
					20																						
					21																						
					22																						
					23																						
					24																						
					25																						
					26																						
					27																						
					28																						
					29																						
					30																						
					31																						

2nd Quarter Ends PP12 (7-12)

SEPTEMBER							OCTOBER							NOVEMBER							DECEMBER						
S	M	T	W	Th	F	S	S	M	T	W	Th	F	S	S	M	T	W	Th	F	S	S	M	T	W	Th	F	S
					DTA															End PP23							
					1																						
					2																						
					3																						
					4																						
					5																						
					6																						
					7																						
					8																						
					9																						
					10																						
					11																						
					12																						
					13																						
					14																						
					15																						
					16																						
					17																						
					18																						
					19																						

# Short Term Disability (STD) Claims Push Email Reports

## Report Description

### First Notice Claim Report

This report will be produced each time a County employee calls the Hartford to file a Short Term Disability claim. Each designated Contact will receive this report for employee's STD claims filed under the Departments/Divisions they manage.

Date Of Report: 11/22/2004  
Report Number: E401703R

Employee Name  
Class: All Classes

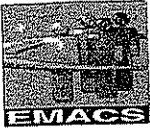
Notification Date

The Hartford  
Employee Benefits Division  
New Claim Report  
For Case: SAMPLE TEST COMPANY  
From 8/31/09 THRU 9/4/09

Reported Last Day of Work

Activity	Description	Status Dt	Last Day Worked	Supervisor Name	Supervisor Phone
New Claim	Employee Called	8/31/09	8/31/09	Supv 1	(909) 555-5555
SSN: xxx-xx-xxxx	Name: Doe, JANE				
New Claim	Employee Called	8/31/09	9/1/09	Supv 2	(909) 666-6666
SSN: xxx-xx-xxxx	Name: Davis, Mary JANE				
New Claim	Employee Called	8/31/09	9/4/09	Supv 3	(909) 777-7777
SSN: xxx-xx-xxxx	Name: Smith, John				
New Claim	Employee Called	8/31/09	9/1/09	Supv 4	(909) 888-8888
SSN: xxx-xx-xxxx	Name: Miles, Robert				

Sample 1



Ensure the most current form is submitted. Refer to EMACS Forms/Procedures website.

## LEAVE INTEGRATION REQUEST (STD, SDI and WORKERS' COMPENSATION)

NOTICE: This form must immediately be submitted for processing based on the distribution choice below.  
Integration choice will begin based on date this form is received.  
**NO FUTURE OR RETRO PROCESSING WILL BE MADE.**

Must print in Black or Blue ink ONLY		Last Name, First Name		Department ID
Employee ID	Rcd No.	DOE, JANE		32710
A0000	0			
Type of Request	Type of Integration	Type of Benefit Payments		Department Name
<input checked="" type="checkbox"/> New Request	<input checked="" type="checkbox"/> Full	<input checked="" type="checkbox"/> Short Term Disability (STD)		ACR
<input type="checkbox"/> Revised	<input type="checkbox"/> No Integration	<input type="checkbox"/> Workers' Compensation		Union Code
Date of Injury	<input type="checkbox"/> Partial Integration – List number of hours per pay period:		ADM	
9/1/2009				

### Requested Order of Use

Default Order of Use – Check box if requesting to use leave in the order listed, as applicable  
Requested Order of Use – Check box if requesting an order other than default, enter the requested order of leave to be used, as applicable

Sick Only – Check box if requesting to use sick leave time only

**Note:** Leaves will be used until exhausted, and then the next designated leave will be used. Sick Leave must be used first in accordance with the MOU.

**If a box is not checked the default order will be used.**

Type of Leave	<input checked="" type="checkbox"/> Default Order of Use	<input type="checkbox"/> Requested Order of Use	<input type="checkbox"/> Sick Only
Sick	1	1	1
Vacation	2		
Holiday	3		
Compensatory Time	4		
Annual	5		
Administrative	6		
Attorney	7		
Other:	8		
Medical Emergency Leave (MEL) <small>Must be integrated with STD</small>	Medical Emergency Leave (MEL) donations will be integrated with STD when all leave accruals have been exhausted.		

I understand that all leave benefits will be administered in accordance with the MOU and County policy. I have received a copy of the Leave Integration Guidelines (page 2 of this form). I authorize my supervisor, department payroll specialist and/or EMACS-Payroll to code or modify my paid time to be consistent with this Leave Integration Request. I understand that the maximum amount of pay that I am allowed to receive while out on leave and integrating with another benefit (disability or Workers' Compensation payments) shall not exceed 100% of my base salary.

Form Completed by Employee – Signature Required	Telephone	Date
<i>Jane Doe</i>	(909) 386-1234	8/28/2009

**\* I have been given authorization and direction on completing this form on behalf of the above employee.**

*Appointee Signature [(Employee not available) Print & Sign]	Telephone	Date
	( )	
Supervisor or Appointing Designee Signature	Title	Date
<i>Supervisor II</i>	SUPV	8/31/2009
Payroll Specialist Name (Print & Sign)	Telephone	Date
Payroll Specialist <i>Payroll Specialist</i>	(909) 386-234	9/1/2009

DISTRIBUTION: Original – STD-EBSD-Hospitality (0015)  
SDI – EMACS – Payroll (0030)  
Workers' Comp – EMACS-Payroll (0030)  
Copy – Department, Supervisor, Employee

Sample 2a

Short Term Disability (STD) Claims  
Push Email Reports

Explanation of Benefits Summary

This report provides a summary of regular benefit payments made for each employee for the selected time period. This can be sent on a daily or weekly basis.

1

Program Number: E401069R  
Date of Report: 9-11-09

The Hartford  
Explanation Of Benefits Summary  
For Case: SAMPLE, INC.

Location: ALL ACTIVE FULL-TIME CT HOURLY EMPLOYEES (ASO)  
Class: ALL HOURLY EES LOCATED IN CT WITH > 15

SSN: xxx-xx-xxxx  
Employee Name: Doe, JANE  
Payee Name: Doe, JANE  
Payee Address: 2 Douglas Way  
Farmington, CT 06032

Check Number: 12331

Coverage: WD  
State: CT

A0000  
base rate  
\$ 30.92  
PP 19/09

Payment Details

Gross Benefit: 388.56  
Net Benefit: 388.56  
Adjustment Amount: 0.00  
Payment Amount: 388.56

Authorized End Date: 10-13-09  
Benefit Start Date: 9-1-09  
Last Day Worked: 8-31-09  
Payment From Date: 9-8-09  
Payment Thru Date: 9-11-09  
Payment Date: 9-11-09

\*\*\*\*\* Taxes \*\*\*\*\*

State: 0.00  
FIT: 0.00  
State: 0.00  
OASH: 0.00  
MDCR: 0.00

\*\*\*\*\* Deductions \*\*\*\*\*

DNIL PRE 0.00

\*\*\*\*\* Offsets \*\*\*\*\*

NFLT 7.00

Remarks:

\* 7 day waiting period  
from 9-1-09 thru 9-7-09

The payment from  
and thru dates  
outline the period  
the payment is  
covering.

Sample 2b

Processing information for Jane Doe A0000

Payment for dates of 9/8/09 thru 9/11/09 (pay period 19/09)

County of San Bernardino  
Human Resources Department

**Short Term Disability Calculator**      **Employee Benefits and Services**

---

This calculator is designed to help you compute the number of hours to code on the TLR for STD payment. You will need the STD Weekly Benefit amount and the hourly rate of the employee. If you do not have the STD Weekly Benefit amount, please contact Employee Benefits and Services - Hospitality at (909) 386-8600 for further information. The result in the "STD adjusted hours for the TLR" box should be coded on the TLR.

Enter STD weekly amount: \$ 388.56

Enter Employee hourly rate: \$ 30.92

STD adjusted hours for the TLR: 12.50

eTime codes information for Jane Doe PP 19/09

**EMACS** New Window

Home > Self Service > Employee > Tasks > eTime Entry

Employee ID: A0000 Rcd: 0 Doe, JANE Job Title: Pay Period End: 09/11/09

Deadline Time: 09/15/09 11:00AM ☐ Show Labor Distribution

**Job Information**

Time Worked from 08/29/09 through 09/11/09

	Sat 8/29	Sun 8/30	Mon 8/31	Tue 9/1	Wed 9/2	Thu 9/3	Fri 9/4	Sat 9/5	Sun 9/6	Mon 9/7	Tue 9/8	Wed 9/9	Thu 9/10	Fri 9/11	Total	TRC	Delete Line
1			8.00												8.00	REG	<input type="button" value="Delete Line"/>
2				8.00	8.00	8.00	8.00					3.50	8.00	8.00	31.50	SCK	<input type="button" value="Delete Line"/>
3										8.00					8.00	HOL	<input type="button" value="Delete Line"/>
4											8.00	4.50			12.50	HSF	<input type="button" value="Delete Line"/>
5																	<input type="button" value="Delete Line"/>
6			8.00	8.00	8.00	8.00	8.00		8.00	8.00	8.00	8.00	8.00	8.00	80.00	TOTAL	

	Amount
Leave Balance	1378.017
Sick	226.489
Vacation	40.000
Admin Lv	1.250
Annual Lv	303.000
Holiday	80.000
Comp Time	7.250
Perf Attnd	

**Hour Summary**      Week 1      Week 2

Request Status

1 day  
waiting

10:1 day  
ON  
9/17/09

Fully  
integrating

will receive  
accruals on  
12.50 hrs  
but no pay

Sample 2b

Short Term Disability (STD) Claims  
Push Email Reports

Explanation of Benefits Summary

This report provides a summary of regular benefit payments made for each employee for the selected time period. This can be sent on a daily or weekly basis.

1

Program Number: E401089R  
Date of Report: 9-18-09

The Hartford  
Explanation Of Benefits Summary  
For Case: SAMPLE, INC.

Location: ALL ACTIVE FULL-TIME CT HOURLY EMPLOYEES (ASO)  
Class: ALL HOURLY EES LOCATED IN CT WITH > 15

SSN: xxx-xx-xxxx  
Employee Name: Doe, JANE  
Payee Name: Doe, JANE  
Payee Address: 2 Douglas Way  
Farmington, CT 06032

Check Number: 14322

Coverage: WD  
State: CT

Payment Details  
Gross Benefit: 680.24  
Net Benefit: 680.24  
Adjustment Amount: 0.00  
Payment Amount: 680.24

Authorized End Date: 10-13-09  
Benefit Start Date: 9-1-09  
Last Day Worked: 8-31-09  
Payment From Date: 9-12-09  
Payment Thru Date: 9-18-09  
Payment Date: 9-18-09

\*\*\*\*\* Taxes \*\*\*\*\*

State: 0.00  
FIT: 0.00  
State: 0.00  
OASD: 0.00  
MDCR: 0.00

\*\*\*\*\* Deductions \*\*\*\*\*

DNTL PRE 0.00

\*\*\*\*\* Offsets \*\*\*\*\*

NFLT 7.00

Remarks:

The payment from  
and thru dates  
outline the period  
the payment is  
covering.

Sample 2c

PP 20/09  
WK 1  
A0000  
\$30.92

# Short Term Disability (STD) Claims Push Email Reports

## Explanation of Benefits Summary

This report provides a summary of regular benefit payments made for each employee for the selected time period. This can be sent on a daily or weekly basis.

1

Program Number: E401089R  
Date of Report: 9-25-09

The Hartford  
Explanation Of Benefits Summary  
For Case: SAMPLE, INC.

Location: ALL ACTIVE FULL-TIME CT HOURLY EMPLOYEES (ASO)  
Class: ALL HOURLY EES LOCATED IN CT WITH > 15

SSN: xxx-xx-xxxx  
Employee Name: DOE, JANE  
Payee Name: DOE, JANE  
Payee Address: 2 Douglas Way  
Farmington, CT 06032

Check Number: N/A

Coverage: WD  
State: CT

### Payment Details

Gross Benefit: 680.24  
Net Benefit: 680.24  
Adjustment Amount: 0.00  
Payment Amount: 680.24

Authorized End Date: 10-13-09  
Benefit Start Date: 9-1-09  
Last Day Worked: 8-31-09  
Payment From Date: 9-19-09  
Payment Thru Date: 9-25-09  
Payment Date: 9-25-09

#### \*\*\*\*\* Taxes \*\*\*\*\*

State: 0.00  
FIT: 0.00  
State: 0.00  
OASD: 0.00  
MDCR: 0.00

#### \*\*\*\*\* Deductions \*\*\*\*\*

DNIL PRE 0.00

#### \*\*\*\*\* Offsets \*\*\*\*\*

NFLT 7.00

Remarks:

The payment from  
and thru dates  
outline the period  
the payment is  
covering.

Sample 2d

PP 20/09  
WK 2  
A0000  
\$30.92

## Weekly payment for Jane Doe

County of San Bernardino  
Human Resources Department  
Employee Benefits and Services

### Short Term Disability Calculator

---

This calculator is designed to help you compute the number of hours to code on the TLR for STD payment. You will need the STD Weekly Benefit amount and the hourly rate of the employee. If you do not have the STD Weekly Benefit amount, please contact Employee Benefits and Services - Hospitality at (809) 396-8500 for further information. The result in the "STD adjusted hours for the TLR" box should be coded on the TLR.

Enter STD weekly amount:

Enter Employee hourly rate:

STD adjusted hours for the TLR:

Absence request update for Jane Doe (pay periods 20-22)  
After initial starting payment, 22 hours of STD will be paid each week by Hartford

Employee has enough leave to fully integrate (per integration form)

Absence request will show 22 hours HSF and 18 hours of SCK each week

Absence request can be done for weeks ending

- ☐ 9/18/09
- ☐ 9/25/09
- ☐ 10/2/09
- ☐ 10/9/09

Home > Ref Services > Managers > Tasks > eTime Absence Request

#### eTime Absence Request

##### Find an Existing Value

EmpID:

Empi Rad Nbr:

Pay Period End Date:

Request Number:

Last Name:

Department:

Request Status:

[Add a New Value](#)

Home > Ref Services > Managers > Tasks > eTime Absence Request

#### eTime Absence Request

##### Add New Value

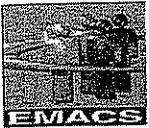
Employee ID:  Rad:  Add Time:  Pay Period End:

Day	Start	Stop	Rate	Hours	Rate	Hours	Rate	Hours	Rate	Hours	Total	Rate	Comments
Mon	08:00	05:00	00	00	00	00	00	00	00	00	00:00	00	
Tue	08:00	05:00	00	00	00	00	00	00	00	00	00:00	00	
Wed	08:00	05:00	00	00	00	00	00	00	00	00	00:00	00	
Thu	08:00	05:00	00	00	00	00	00	00	00	00	00:00	00	
Fri	08:00	05:00	00	00	00	00	00	00	00	00	00:00	00	
Sat	08:00	05:00	00	00	00	00	00	00	00	00	00:00	00	
Sun	08:00	05:00	00	00	00	00	00	00	00	00	00:00	00	
<b>TOTAL</b>											<b>00:00</b>		

Request ID:  Request Number:  Request Status:

Request ID:  Request Number:  Request Status:

Sample 2e



Ensure the most current form is submitted. Refer to EMACS Forms/Procedures website.

## LEAVE INTEGRATION REQUEST (STD, SDI and WORKERS' COMPENSATION)

NOTICE: This form must immediately be submitted for processing based on the distribution choice below.  
Integration choice will begin based on date this form is received.  
**NO FUTURE OR RETRO PROCESSING WILL BE MADE.**

Must print in Black or Blue ink ONLY			
Employee ID A1111	Rcd No. 0	Last Name, First Name DAVIS, MARY JANE	Department ID 32510
Type of Request <input checked="" type="checkbox"/> New Request <input type="checkbox"/> Revised	Type of Integration <input type="checkbox"/> Full <input type="checkbox"/> No Integration <input checked="" type="checkbox"/> Partial Integration – List number of hours per pay period: 20.00	Type of Benefit Payments <input checked="" type="checkbox"/> Short Term Disability (STD) <input type="checkbox"/> Workers' Compensation <input type="checkbox"/> State Disability Insurance (SDI)	Department Name ACR
Date of Injury 9/2/2009			Union Code SUP

### Requested Order of Use

Default Order of Use – Check box if requesting to use leave in the order listed, as applicable

Requested Order of Use – Check box if requesting an order other than default, enter the requested order of leave to be used, as applicable

Sick Only – Check box if requesting to use sick leave time only

**Note:** Leaves will be used until exhausted, and then the next designated leave will be used. Sick Leave must be used first in accordance with the MOU.

If a box is not checked the default order will be used.

Type of Leave	<input type="checkbox"/> Default Order of Use	<input checked="" type="checkbox"/> Requested Order of Use	<input type="checkbox"/> Sick Only
Sick	1	1	1
Vacation	2	3	
Holiday	3	4	
Compensatory Time	4	5	
Annual	5	2	
Administrative	6	6	
Attorney	7	7	
Other:	8	8	
Medical Emergency Leave (MEL) <i>Must be integrated with STD</i>	Medical Emergency Leave (MEL) donations will be integrated with STD when all leave accruals have been exhausted.		

I understand that all leave benefits will be administered in accordance with the MOU and County policy. I have received a copy of the Leave Integration Guidelines (page 2 of this form). I authorize my supervisor, department payroll specialist and/or EMACS-Payroll to code or modify my paid time to be consistent with this Leave Integration Request. I understand that the maximum amount of pay that I am allowed to receive while out on leave and integrating with another benefit (disability or Workers' Compensation payments) shall not exceed 100% of my base salary.

Form Completed by Employee – Signature Required <i>Mary Jane Davis</i>	Telephone (909) 386-3333	Date 8/31/2009
---	-----------------------------	-------------------

\* I have been given authorization and direction on completing this form on behalf of the above employee.

*Appointee Signature [(Employee not available) Print & Sign]	Telephone ( )	Date
Supervisor or Appointing Designee Signature <i>Supervisor</i>	Title SUPV	Date 8/31/2009
Payroll Specialist Name (Print & Sign) Payroll Specialist <i>Payroll Specialist</i>	Telephone (909) 386-234	Date 9/1/2009

DISTRIBUTION: Original – STD-EBSD-Hospitality (0015)  
SDI – EMACS – Payroll (0030)  
Workers' Comp – EMACS-Payroll (0030)  
Copy – Department, Supervisor, Employee

Sample 3a

# Short Term Disability (STD) Claims Push Email Reports

## Explanation of Benefits Summary

This report provides a summary of regular benefit payments made for each employee for the selected time period. This can be sent on a daily or weekly basis.

1

Program Number: E401089R  
Date of Report: 9-11-09

The Hartford  
Explanation Of Benefits Summary  
For Case: SAMPLE, INC.

A1111  
base rate \$ 23.64

Location: ALL ACTIVE FULL-TIME CT HOURLY EMPLOYEES (ASO)  
Class: ALL HOURLY EES LOCATED IN CT WITH > 15

SSN: xxx-xx-xxxx  
Employee Name: DAVIS, MARY JANE  
Payee Name: DAVIS, MARY JANE  
Payee Address: 2 Douglas Way  
Farmington, CT 06032

Check Number: N/A

Coverage: WD  
State: CT

### Payment Details

Gross Benefit: 222.90  
Net Benefit: 222.90  
Adjustment Amount: 0.00  
Payment Amount: 204.67

Authorized End Date: 11-2-09  
Benefit Start Date: 9-2-09  
Last Day Worked: 9-1-09  
Payment From Date: 9-9-09  
Payment Thru Date: 9-11-09  
Payment Date: 9-11-09

#### \*\*\*\*\* Taxes \*\*\*\*\*

State: 0.00  
FTI: 10.00  
State: 5.00  
CASH: 3.23  
MDCR: 3.23

#### \*\*\*\*\* Deductions \*\*\*\*\*

DNIL PRE 0.00

#### \*\*\*\*\* Offsets \*\*\*\*\*

NFLT 7.06

Taxes taken from payment

Remarks:

\* 7 day waiting period  
from 9-2-09 thru 9-8-09

The payment from  
and thru dates  
outline the period  
the payment is  
covering.

Processing information for Mary Jane Davis

County of San Bernardino  
Human Resources Department

## Short Term Disability Calculator

Employee Benefits and Services

---

This calculator is designed to help you compute the number of hours to code on the TLR for STD payment. You will need the STD Weekly Benefit amount and the hourly rate of the employee. If you do not have the STD Weekly Benefit amount, please contact Employee Benefits and Services - Hospitality at (909) 386-8600 for further information. The result in the "STD adjusted hours for the TLR" box should be coded on the TLR.

Enter STD weekly amount: \$222.90

Enter Employee hourly rate: \$23.64

STD adjusted hours for the TLR: 9.50

eTime coding

**EMACS** Home > Self Service > Employee > Tasks > eTime Entry New Window

Employee ID: A1111 Rcd: 0 DAVIS, MARY JANE Job Title: Pay Period End: 09/11/09

Deadline Time: 09/15/09 11:00AM ☐ Show Labor Distribution

**Job Information**

Time Worked from 08/29/09 through 09/11/09

	Sat 8/29	Sun 8/30	Mon 8/31	Tue 9/1	Wed 9/2	Thu 9/3	Fri 9/4	Sat 9/5	Sun 9/6	Mon 9/7	Tue 9/8	Wed 9/9	Thu 9/10	Fri 9/11	Total	TRC	Delete Line	
1			8.00	8.00											16.00	REG	<input type="button" value="Delete Line"/>	
2					8.00	8.00	8.00				8.00	8.00	2.00				SCK	<input type="button" value="Delete Line"/>
3										8.00							HOL	<input type="button" value="Delete Line"/>
4													1.50	8.00			HSP	<input type="button" value="Delete Line"/>
5													4.50				WOPSK	<input type="button" value="Delete Line"/>
6			8.00	8.00	8.00	8.00	8.00		8.00	8.00	8.00	8.00	8.00	8.00	80.00	TOTAL		

Leave Balance	Amount	Hour Summary	Week 1	Week 2
Sick	100.00			
Vacation	130.489			
Admin Lv	40.000			
Annual Lv	1.250			
Holiday	.000			
Comp Time	3.000			

Request Status: Total Amount: 1.25

waiting  
period

NO Accruals  
ON HSP

Sample 3c

Short Term Disability (STD) Claims  
Push Email Reports

Explanation of Benefits Summary

This report provides a summary of regular benefit payments made for each employee for the selected time period. This can be sent on a daily or weekly basis.

1

Program Number: E401089R  
Date of Report: 9-18-09

The Hartford  
Explanation Of Benefits Summary  
For Case: SAMPLE, INC.

Location: ALL ACTIVE FULL-TIME CT HOURLY EMPLOYEES (ASO)  
Class: ALL HOURLY EES LOCATED IN CT WITH > 15

SSN: xxx-xx-xxxx  
Employee Name: DAVIS, MARY JANE  
Payee Name: DAVIS, MARY JANE  
Payee Address: 2 Douglas Way  
Farmington, CT 06032

Check Number: N/A

Coverage: WD  
State: CT

Payment Details  
Gross Benefit: 520.08  
Net Benefit: 520.08  
Adjustment Amount: 0.00  
Payment Amount: 497.54

Authorized End Date: 11-2-09  
Benefit Start Date: 9-2-09  
Last Day Worked: 9-1-09  
Payment From Date: 9-12-09  
Payment Thru Date: 9-18-09  
Payment Date: 9-18-09

\*\*\*\*\* Taxes \*\*\*\*\*

State: 0.00  
FIT: 10.00  
State: 5.00  
OASD: 0.00  
MDCR: 7.54

\*\*\*\*\* Deductions \*\*\*\*\*

DNIL PRE 0.00

\*\*\*\*\* Offsets \*\*\*\*\*

NFLT 7.00

Remarks:

The payment from  
and thru dates  
outline the period  
the payment is  
covering.

Sample 3d

County of San Bernardino  
Human Resources Department

**Short Term Disability Calculator** **Employee Benefits and Services**

---

This calculator is designed to help you compute the number of hours to code on the TLR for STD payment. You will need the STD Weekly Benefit amount and the hourly rate of the employee. If you do not have the STD Weekly Benefit amount, please contact Employee Benefits and Services – Hospitality at (909) 386-8600 for further information. The result in the "STD adjusted hours for the TLR" box should be coded on the TLR.

Enter STD weekly amount:

Enter Employee hourly rate:

STD adjusted hours for the TLR:

The employee must use sick without pay (WOPSK) for the remaining hours per week. Employee must code HSP as WOPSK is used in the pay period.

[Home](#) > [Self Service](#) > [Manager](#) > [Tasks](#) > [eTime Absence Request](#)

## eTime Absence Request

---

### Find an Existing Value

EmplID:   
 Empl Rcd Nbr:   
 Pay Period End Date:    
 Request Number:   
 Last Name:   
 Department:   
 Request Status:

[Add a New Value](#)

[Home](#) > [Self Service](#) > [Employees](#) > [Timesheets](#) > [Time Absences Request](#) [New Window](#)

Employee ID: **4000000000**      Job Title: **Sup. ADR Payroll Technician**      Pay Period End: **06/11/09**

Absence Type: **Time Off**      From: **06/01/09** Through: **06/01/09** (Include Pay Period)

Sat	Sun	Mon	Tue	Wed	Thur	Fri	Sat	Sun	Mon	Tue	Wed	Thur	Fri	Total	TRC	Comments	Delete Line
8/79	8/20	8/21	8/22	8/23	8/24	8/25	8/26	8/27	8/28	8/29	8/30	8/31	9/1				
														0.00	0.00		Delete Line
2														6.00	TOTAL		

Add Link: [Save for Later](#)      [Request for Approval](#)

**Leave Balances**      Amount

Annual Leave: 10.00  
 Sick Leave: 10.00  
 Vacation: 10.00  
 Other: 10.00

**Request Status**

Request for: **Work Schedule**  
 by:   
 on:

Sample 3e



Ensure the most current form is submitted. Refer to EMACS Forms/Procedures website.

## LEAVE INTEGRATION REQUEST (STD, SDI and WORKERS' COMPENSATION)

NOTICE: This form must immediately be submitted for processing based on the distribution choice below.  
Integration choice will begin based on date this form is received.  
**NO FUTURE OR RETRO PROCESSING WILL BE MADE.**

Must print in Black or Blue ink ONLY		Last Name, First Name SMITH, JOHN		Department ID 32700
Employee ID A2222	Rcd No. 0			Department Name
Type of Request	Type of Integration	Type of Benefit Payments		
<input checked="" type="checkbox"/> New Request <input type="checkbox"/> Revised	<input checked="" type="checkbox"/> Full <input type="checkbox"/> No Integration	<input checked="" type="checkbox"/> Short Term Disability (STD) <input type="checkbox"/> Workers' Compensation <input type="checkbox"/> State Disability Insurance (SDI)		ACR
Date of Injury 9/4/2009	<input type="checkbox"/> Partial Integration – List number of hours per pay period:			Union Code CLK

### Requested Order of Use

Default Order of Use – Check box if requesting to use leave in the order listed, as applicable

Requested Order of Use – Check box if requesting an order other than default, enter the requested order of leave to be used, as applicable

Sick Only – Check box if requesting to use sick leave time only

**Note:** Leaves will be used until exhausted, and then the next designated leave will be used. Sick Leave must be used first in accordance with the MOU.

**If a box is not checked the default order will be used.**

Type of Leave	<input type="checkbox"/> Default Order of Use	<input type="checkbox"/> Requested Order of Use	<input checked="" type="checkbox"/> Sick Only
Sick	1	1	1
Vacation	2		
Holiday	3		
Compensatory Time	4		
Annual	5		
Administrative	6		
Attorney	7		
Other:	8		
Medical Emergency Leave (MEL) <i>Must be integrated with STD</i>	Medical Emergency Leave (MEL) donations will be integrated with STD when all leave accruals have been exhausted.		

I understand that all leave benefits will be administered in accordance with the MOU and County policy. I have received a copy of the Leave Integration Guidelines (page 2 of this form). I authorize my supervisor, department payroll specialist and/or EMACS-Payroll to code or modify my paid time to be consistent with this Leave Integration Request. I understand that the maximum amount of pay that I am allowed to receive while out on leave and integrating with another benefit (disability or Workers' Compensation payments) shall not exceed 100% of my base salary.

Form Completed by Employee – Signature Required 	Telephone (909) 386-4444	Date 8/31/2009
---	-----------------------------	-------------------

**\* I have been given authorization and direction on completing this form on behalf of the above employee.**

*Appointee Signature [(Employee not available) Print & Sign]	Telephone ( )	Date
Supervisor or Appointing Designee Signature 	Title SUPV:	Date 8/31/2009
Payroll Specialist Name (Print & Sign) Payroll Specialist	Telephone (909) 386-2304	Date 9/2/2009

DISTRIBUTION: Original – STD-EBSD-Hospitality (0015)  
SDI – EMACS – Payroll (0030)  
Workers' Comp – EMACS-Payroll (0030)  
Copy: Department Supervisor Employee

Sample 4a

# Short Term Disability (STD) Claims Push Email Reports

## Explanation of Benefits Summary

This report provides a summary of regular benefit payments made for each employee for the selected time period. This can be sent on a daily or weekly basis.

1

Program Number: E401089R  
Date of Report: 10-16-09

The Hartford  
Explanation Of Benefits Summary  
For Case: SAMPLE, INC.

Location: ALL ACTIVE FULL-TIME CT HOURLY EMPLOYEES (ASO)  
Class: ALL HOURLY EES LOCATED IN CT WITH > 15

SSN: xxx-xx-xxxx  
Employee Name: Smith, John  
Payee Name: Smith, John  
Payee Address: 2 Douglas Way  
Farmington, CT 06032

Check Number: N/A

Coverage: WD  
State: CT

Payment Details

Gross Benefit: 179.90  
Net Benefit: 179.90  
Adjustment Amount: 0.00  
Payment Amount: 177.29

Authorized End Date: 11-13-09  
Benefit Start Date: 9-5-09  
Last Day Worked: 9-4-09  
Payment From Date: 10-10-09  
Payment Thru Date: 10-16-09  
Payment Date: 10-16-09

### \*\*\*\*\* Taxes \*\*\*\*\*

State: 0.00  
FIT: 0.00  
State: 0.00  
OASD: 0.00  
MDCR: 2.61

### \*\*\*\*\* Deductions \*\*\*\*\*

DNIL PRE 0.00

### \*\*\*\*\* Offsets \*\*\*\*\*

NFLT 7.00

Remarks:

The payment from and thru dates outline the period the payment is covering.

Sample 4b

# Processing information for John Smith

County of San Bernardino  
Human Resources Department

## Short Term Disability Calculator

Employee Benefits and Services

This calculator is designed to help you compute the number of hours to code on the TLR for STD payment. You will need the STD Weekly Benefit amount and the hourly rate of the employee. If you do not have the STD Weekly Benefit amount, please contact Employee Benefits and Services - Hospitality at (909) 385-8600 for further information. The result in the "STD adjusted hours for the TLR" box should be coded on the TLR.

Enter STD weekly amount: \$179.90

Enter Employee hourly rate: \$14.87

Calculate adjusted hours

STD adjusted hours for the TLR: 12.00

Reset

# eTime coding information for John Smith

EMACS New Window

Home > Self Service > Employee > Tasks > eTime Entry

Employee ID: A2222 Job Title: Smith, John Pay Period End:

Deadline Time: Rcd: 0 Show Labor Distribution Reload Defaults

Job Information

Time Worked from 08/25/09 through 09/14/09

	Sat 8/29/09	Sun 8/30/09	Mon 8/31/09	Tue 9/01/09	Wed 9/02/09	Thu 9/03/09	Fri 9/04/09	Sat 9/05/09	Sun 9/06/09	Mon 9/07/09	Tue 9/08/09	Wed 9/09/09	Thu 9/10/09	Fri 9/11/09	Total	TRC	Delete Line
1			4.00	4.00	4.00	4.00	4.00			4.00	4.00	4.00	4.00	4.00		REG	Delete Line
2						4.00	4.00						4.00	4.00		SCK	Delete Line
3			4.00	4.00	4.00					4.00	4.00	4.00				HSE	Delete Line
4																	Delete Line
5																	Delete Line
6			8.00	8.00	8.00	8.00	8.00			8.00	8.00	8.00	8.00	8.00	88.00	TOTAL	

Add Line Save for Later Submit for Approval

Leave Balance Amount: 200.01

Vacation

Hour Summary Week 1 Week 2

Sample 4 c

## Absence request

**EMACS**  
 Home > Self Service > Manager > Tasks > eTime Absence Request

**eTime Absence Request**

**Find an Existing Value**

EmpID:

Empi Rod Nbr:

Pay Period End Date:

Request Number:

Last Name:

Department:

Request Status:

[Add a New Value](#)

**EMACS**  
 Home > Self Service > Employee > Tasks > eTime Absence Request

Employee ID: Rod: 01 Job Title: Sup ACR Payroll Technician Pay Period End: 09/11/09

Absence Requested from 09/08/09 to 09/11/09 (Future Pay Period)

Sat 8/29	Sun 8/30	Mon 8/31	Tue 9/1	Wed 9/2	Thu 9/3	Fri 9/4	Sat 9/5	Sun 9/6	Mon 9/7	Tue 9/8	Wed 9/9	Thu 9/10	Fri 9/11	Total	TRC	Comments	Delete Line
														0.00			
														0.00	TOTAL		

Leave Balance Amount

Request Status

Request No: Work Schedule: 9/80 - Second Monday Off

by

by

Absence request would be completed for HSF and sick leave only.  
 REG hours would come over from preferences.

Sample 4d



Ensure the most current form is submitted. Refer to EMACS Forms/Procedures website.

## LEAVE INTEGRATION REQUEST (STD, SDI and WORKERS' COMPENSATION)

NOTICE: This form must *immediately* be submitted for processing based on the distribution choice below.  
*Integration choice will begin based on date this form is received.*  
**NO FUTURE OR RETRO PROCESSING WILL BE MADE.**

Must print in Black or Blue ink ONLY			
Employee ID A3333	Rcd No. 0	Last Name, First Name MILES, ROBERT	Department ID 32500
Type of Request <input checked="" type="checkbox"/> New Request <input type="checkbox"/> Revised	Type of Integration <input checked="" type="checkbox"/> Full <input type="checkbox"/> No Integration <input type="checkbox"/> Partial Integration – List number of hours per pay period:	Type of Benefit Payments <input checked="" type="checkbox"/> Short Term Disability (STD) <input type="checkbox"/> Workers' Compensation <input type="checkbox"/> State Disability Insurance (SDI)	Department Name ACR
Date of Injury 9/1/2009			Union Code T & I

### Requested Order of Use

Default Order of Use – Check box if requesting to use leave in the order listed, as applicable

Requested Order of Use – Check box if requesting an order other than default, enter the requested order of leave to be used, as applicable

Sick Only – Check box if requesting to use sick leave time only

**Note:** Leaves will be used until exhausted, and then the next designated leave will be used. Sick Leave must be used first in accordance with the MOU.

**If a box is not checked the default order will be used.**

Type of Leave	<input checked="" type="checkbox"/> Default Order of Use	<input type="checkbox"/> Requested Order of Use	<input type="checkbox"/> Sick Only
Sick	1	1	1
Vacation	2		
Holiday	3		
Compensatory Time	4		
Annual	5		
Administrative	6		
Attorney	7		
Other:	8		
Medical Emergency Leave (MEL) <i>Must be integrated with STD</i>	Medical Emergency Leave (MEL) donations will be integrated with STD when all leave accruals have been exhausted.		

I understand that all leave benefits will be administered in accordance with the MOU and County policy. I have received a copy of the Leave Integration Guidelines (page 2 of this form). I authorize my supervisor, department payroll specialist and/or EMACS-Payroll to code or modify my paid time to be consistent with this Leave Integration Request. I understand that the maximum amount of pay that I am allowed to receive while out on leave and integrating with another benefit (disability or Workers' Compensation payments) shall not exceed 100% of my base salary.

Form Completed by Employee – Signature Required 	Telephone (909) 386-5555	Date 8/31/2009
---	-----------------------------	-------------------

*\* I have been given authorization and direction on completing this form on behalf of the above employee.*

*Appointee Signature [(Employee not available) Print & Sign]	Telephone ( )	Date
Supervisor or Appointing Designee Signature 	Title SUPV	Date 8/31/2009
Payroll Specialist Name (Print & Sign) Payroll Specialist	Telephone (909) 386-2304	Date 9/1/2009

DISTRIBUTION: Original – STD-EBSD-Hospitality (0015)  
SDI – EMACS – Payroll (0030)  
Workers' Comp – EMACS-Payroll (0030)  
Copy – Department Supervisor, Employee

Sample 5a

Short Term Disability (STD) Claims  
Push Email Reports

Explanation of Benefits Summary

This report provides a summary of regular benefit payments made for each employee for the selected time period. This can be sent on a daily or weekly basis.

1

Program Number: E401889R  
Date of Report: 10-12-09

The Hartford  
Explanation Of Benefits Summary  
For Case: SAMPLE, INC.

Location: ALL ACTIVE FULL-TIME CT HOURLY EMPLOYEES (ASO)  
Class: ALL HOURLY EES LOCATED IN CT WITH > 15

SSN: xxx-xx-xxxx  
Employee Name: Robert Miles  
Payee Name: Robert Miles  
Payee Address: 2 Douglas Way  
Farmington, CT 06032

Check Number: N/A

Coverage: WD  
State: CT

Payment Details

Gross Benefit: 162.39  
Net Benefit: 162.39  
Adjustment Amount: 0.00  
Payment Amount: 160.04

Authorized End Date: 10-12-09  
Benefit Start Date: 9-1-09  
Last Day Worked: 8-31-09  
Payment From Date: 10-10-09  
Payment Thru Date: 10-12-09  
Payment Date: 10-12-09

***** Taxes *****		***** Deductions *****		***** Offsets *****	
State:	0.00	DNTL PRE	0.00	NFLT	7.00
FIT:	0.00				
State:	0.00				
OASH:	0.00				
MDCR:	2.35				

Remarks:

The payment from and thru dates outline the period the payment is covering.

Sample 56

\* Ending payment - employee has been receiving \$378.87 a week. employee base rate of pay is \$17.22

Processing information for Robert Miles

County of San Bernardino  
Human Resources Department

## Short Term Disability Calculator

Employee Benefits and Services

---

This calculator is designed to help you compute the number of hours to code on the TLR for STD payment. You will need the STD Weekly Benefit amount and the hourly rate of the employee. If you do not have the STD Weekly Benefit amount, please contact Employee Benefits and Services - Hospitality at (909) 386-8600 for further information. The result in the "STD adjusted hours for the TLR" box should be coded on the TLR.

Enter STD weekly amount: \$162.39

Enter Employee hourly rate: \$17.22

STD adjusted hours for the TLR: 9.50

eTime coding information for Robert Miles PP 22/09  
Employee is not eligible for the HOL earn code as Hartford has paid them for the holiday. The employee will accrue the FHA (holiday) hours.

STD  
payment  
3 days

New Window

Home > Self Service > Employee > Tasks > eTime Entry

A3333 miles, Robert

Employee ID: Rcd: 0 Job Title: Pay Period End:

Deadline Time: ☐ Show Labor Distribution

**Job Information**

Time Worked from 08/29/09 through 09/11/09

	Sat 10/10	Sun 10/11	Mon 10/12	Tue 10/13	Wed 10/14	Thu 10/15	Fri 10/16	Sat 10/17	Sun 10/18	Mon 10/19	Tue 10/20	Wed 10/21	Thu 10/22	Fri 10/23	Total	TRC	Delete Line
1			8.00	8.00	8.00	8.00			8.00	8.00	8.00	8.00	8.00	8.00	48.00	REG	<input type="button" value="Delete Line"/>
2			8.00													HSF	<input type="button" value="Delete Line"/>
3																	<input type="button" value="Delete Line"/>
4																	<input type="button" value="Delete Line"/>
5																	<input type="button" value="Delete Line"/>
6			8.00	8.00	8.00	8.00	8.00			8.00	8.00	8.00	8.00	8.00	80.00	TOTAL	

Add Line Save for Later Submit for Approval

Leave Balance Amount  
Sick 350.010  
Vacation 75.020  
Holiday 0.000

Hour Summary Week 1 Week 2

Request Status

Sample 5c